



The Guardian Life Insurance Company of America

Managed DentalGuard, Inc.
A wholly owned subsidiary of Guardian

GG-015049TX
Enrollment / Change Form

Planholder Name (Company Name)
CSBC EMPLOYMENT SOLUTIONS, INC.
Guardian Group Plan No.:
424900
Planholder Street Address
9821 KATY FREEWAY, SUITE 290
City
HOUSTON
State
TX
Zip
77024

EMPLOYER USE ONLY:
Class
Hours Worked
Division
Benefit Effective
Keep a copy for your records and return to: Western Regional Office, P.O. Box 2454, Spokane, WA 99210-2454

ABOUT YOURSELF - Please print clearly and in black or blue ink
First, Middle Initial, Last Name
Sex:
Date of Birth (mm/dd/yyyy)
Social Security Number
Address
City
State
Zip
The best way to reach you:
Business Phone#
Home Phone #
Preferred Email
Job Title:
Work Status/Eligibility:
Date work status began:
Annual Salary/Earnings:
ARE YOU MARRIED?
DO YOU HAVE CHILDREN OR OTHER DEPENDENTS?
WHAT IS YOUR PRIMARY LANGUAGE?
DO YOU HAVE A DISABILITY, WHICH WOULD AFFECT YOUR ABILITY TO COMMUNICATE OR READ?

ABOUT YOUR DEPENDENTS
Add
Change
Drop
Spouse First, Middle Initial, Last Name
Sex
Date of Birth (mm/dd/yyyy)
Social Security Number
Marriage Date
Child (1):
Child (2):
Child (3):
Child (4):

To drop coverage for yourself or your dependents, check the box(es) to the left of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverage's.

CHOOSE YOUR DENTAL COVERAGE: Check one box only
Find dental providers online at www.guardianlife.com or check the directory of providers.

Option 1 - DHMO/MDG
Employee Alone
Employee & Spouse
Employee & Child(ren)
Entire Family
I Waive This Coverage

Dental Provider Location # - If electing the DHMO/MDG Plan - List dental office number(s) in the section below.
Employee
Spouse
Child (1)
Child (2)
Child (3)
Child (4)

If waiving coverage, are you covered under another dental plan?
If waiving dependent coverage, are your dependents covered under another dental plan?

If you or your family has lost dental coverage, please explain below. Late entrant penalties may apply.
Reason for Loss of coverage:
Date of coverage loss:
Termination of Employment.
Divorce.
Death of Spouse.
Termination or Expiration of coverage

**IMPORTANT NOTES:**

- Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse/DP, divorce or where a court has ordered coverage be provided for an eligible spouse/DP or eligible children, provided you apply within 31 days.
- Late entrant penalties or proof of insurability do not apply to DHMO dental coverage. The DHMO dental plan refers to, as applicable, Managed DentalGuard Inc. Eligibility for this coverage is only available at the open enrollment period.

**CHOOSE YOUR VISION COVERAGE:** Check one box only

Find vision providers online at [www.guardianlife.com](http://www.guardianlife.com) or check the directory of providers.

**Option 1 – Full Feature**

- |                       |                          |  |
|-----------------------|--------------------------|--|
| Employee Alone        | <input type="checkbox"/> | <input type="checkbox"/> I Waive This Coverage |
| Employee & Spouse     | <input type="checkbox"/> | <input type="checkbox"/> I Waive This Coverage |
| Employee & Child(ren) | <input type="checkbox"/> | <input type="checkbox"/> I Waive This Coverage |
| Entire Family         | <input type="checkbox"/> | <input type="checkbox"/> I Waive This Coverage |

If waiving coverage, are you covered under another vision plan?  Yes  No

If waiving dependent coverage, are your dependents covered under another vision plan?  Yes  No

**IMPORTANT NOTES:**

- If I have waived the vision coverage, and elect coverage at a later date, enrollment delays may apply.
- Your plan includes a One Year Lock-In/Lock-Out Provision - Your election to enroll in or waive Vision coverage must remain in effect until your plan's next annual vision enrollment period.

**SIGNATURE**

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverage's that I have chosen above.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- I attest that the information provided above is true and correct to the best of my knowledge.
- I understand that I must be actively at work or my life and/or disability coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- **Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.**

SIGNATURE OF EMPLOYEE

DATE